



# Sex Education and Reproductive Health Needs of Foster and Transitioning Youth in Three California Counties

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This report and a separate executive summary are available for download at <http://crahd.phi.org>. This study will serve as the basis for the Spring, 2009 release of *No Time for Complacency: Adolescent Sexual Health in California*, including a two-page policy review and a six-page fully formatted fold-open executive summary. These will be available approximately April 7 at the above URL.

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## INTRODUCTION

There are approximately 72,000 children and youth aged 20 years and younger in state-supervised foster care<sup>1</sup> in California, with about 13,000 of these youth aged 16-20 years currently transitioning out of foster care (Needell et al., 2008). Children and youth in foster care are often characterized by the absence of a dependable family or social network, an intense need for affection, the desire to possess something of their own that they do not have to share, exposure to sexual abuse, exposure to other types of violence, and limited skills in identifying and accessing resources to support themselves now and in the future (Becker & Barth, 2000). Studies have shown that youth who grow up in and emancipate from foster care are likely to have poor outcomes in education, employment, housing, and physical and mental health (Aarons et al., 2001; Courtney et al., 2007; Garland et al., 2001; George et al., 2002; Pecora et al., 2006).

Foster and emancipated youth are also at increased risk for unintended pregnancy, HIV, and other sexually transmitted diseases (STDs) due to high-risk sexual behaviors such as unprotected sex and sex with multiple partners (Becker & Barth, 2000), and young women who had been in foster care are more likely to have been pregnant than same-aged peers who had not been in foster care (Courtney et al., 2007). Adolescent parenthood can have considerable costs for both young women and their children, and delaying pregnancy among foster youth is widely considered a worthwhile goal for child welfare policy (Courtney, Dworsky, & Pollack, 2007).

Youth in foster care tend to change schools frequently due to changes in foster placements and thus may experience lapses in school attendance, falling behind not only in academic subjects, but also missing the sex education sometimes delivered in traditional schools. Foster and former foster youth are therefore less likely to have had access to sex education classes, despite their increased risk for unintended pregnancy, HIV, and other STDs.

The following discussion of two large studies on this topic provide more detailed information and further illustrate the challenges facing foster and transitioning youth in the areas of pregnancy prevention and sexual health.

### Chapin Hall Study

The Chapin Hall Center for Children at the University of Chicago conducted a longitudinal survey of foster youth in three Midwestern states (Illinois, Iowa, and Wisconsin). The survey began in 2002 when the youth were 17 years of age and continued until 2007 when the youth were 21 years of age. Among other topics, the youth were asked about sexual behaviors, pregnancy, and children and parenting. Between May 2002 and March 2003, 732 youth were interviewed for the first time, and all youth were 17 or 18 years old at the time. Between March and December 2004, 603 of the 732 youth (82%) were interviewed again, and most of the youth were then 19 years old. Finally, between March 2006 and January 2007, 591 of the original 732 youth (81%) were interviewed for a third time, and nearly all of the youth were 21 years old at that time (Courtney et al., 2007). The authors of the longitudinal survey compared, when possible, their sample of foster youth and former foster youth to a nationally representative sample of same-aged peers who participated in the National Longitudinal Study of Adolescent Health (Add Health). The paragraphs that follow summarize the key finding that relate to sexual behaviors and childbearing for each of the three interview waves.

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<sup>1</sup> The term *foster care* is used generally to refer to all types of out-of-home placements including foster homes, group homes, kin, guardians, and so forth.

First wave of interviews at age 17. Almost 25% of the 17-year-old women who were in foster care reported having received testing or treatment for STDs, in comparison with only 6% of same-aged peers from the Add Health study who were not in foster care (hereafter referred to as peers). Fifteen percent of young women who were in foster care reported having received family planning services and psychological or emotional counseling, nearly three times the percentage of their peers (6%). Overall, 45% of the young women who were in foster care reported having received information on birth control and family planning through independent living services. Yet, young women who were in foster care were almost twice as likely to have ever been pregnant than were their peers (33% vs. 19%). Two-thirds of the young women who were in foster care and had been pregnant said their pregnancy was unwanted, in comparison with slightly over half of their peers. Young women who were in foster care, however, were far less likely to have had an abortion (9%) than were their peers (36%; Courtney, Terao, & Bost, 2004).

Second wave of interviews at age 19. At age 19, the young women who had been in foster care were more likely to report having ever had sexual intercourse (90% vs. 78%), using a condom the last time they had sexual intercourse (48% vs. 37%) and having had a sexual partner with an STD during the past year (18% vs. 6%) than were their peers (Courtney et al., 2005). In addition, young women who had been in foster care were equally likely to report having used birth control the last time they had sexual intercourse (65% vs. 65%), slightly more likely to report never using birth control during the past year (16% vs. 13%), and slightly less likely to report never using condoms during the past year (21% vs. 29%) than were their peers. Further, nearly half of young women who had been in foster care reported they have ever been pregnant, as compared with 20% of their peers, and young women who had been in foster care were twice as likely to have had at least one child. Moreover, the longitudinal survey also found differences between young men and young women who had been in foster care in regard to sexual behaviors. Young women were slightly more likely than young men were to report having ever had sexual intercourse (90% vs. 84%), twice as likely to report having had a sexual partner with an STD during the past year (18% vs. 9%), and twice as likely to report unsafe sexual behaviors such as never using condoms during the past year (21% vs. 10%; Courtney et al., 2005).

At age 19, young women who were no longer in foster care were more likely to have received prenatal or postpartum services if they became pregnant than were young women who were still in care (54% vs. 80%). The authors concluded that some young adults in care are not receiving the services they need. The authors also found, however, that among the young women who became pregnant, those who were still in foster care were more likely to have received family planning services than were young women who were no longer in care (17% vs. 13%; Courtney et al., 2005).

Third wave of interviews at age 21. By age 21, young women (94%) and young men (91%) who had been in foster care were more likely to have ever had sexual intercourse than were same-age young women (88%) and young men (87%) who had not been in foster care. In addition, a higher proportion of young women who had been in foster care reported having had a sexual partner with an STD in the past year as compared with their peers (17% vs. 10%). Among young adults who had been in foster care, nearly 60% of those who had sexual intercourse during the past year reported using contraception all or most of the time, and nearly 50% reported using condoms all or most of the time. Further, a higher proportion of young women who had been in foster care than of their peers reported having used condoms all or most of the time in the past year (46% vs. 38%), but a lower proportion reported having used birth control all or most of the time in the past year (60% vs. 70%). Among young men who had been in foster care, 57% reported having used birth control and 46% reported having used condoms all or most of the time in the past year; among their peers, the percentages were 68% and 46%, respectively (Courtney et al., 2007).

At age 21, 71% of young women who had been in foster care had ever been pregnant, as compared with 34% of their peers. Furthermore, at age 21, 50% of young women who had been in foster care had been pregnant since they were last surveyed at age 19. At age 21, the majority of same-aged young women from the Add Health study had been pregnant once (55%), whereas the majority of young women who had been in foster care had been pregnant two or more times (62%). Half of the young men who had been in foster care reported that they had ever gotten a female pregnant, compared with 19% of their peers who had not been in foster care. Both young women and young men who had been in foster care were more than twice as likely as their peers were to have at least one living child.

Further, at the age of 21, 30% of the young women who had been in foster care and who had been pregnant since their last interview said they wanted to become pregnant, and only a quarter of them were using birth control when they conceived (Courtney et al., 2007).

Among young women who had been in foster care, a large majority of those who had been pregnant since they were last surveyed at age 19 had received prenatal care during their most recent pregnancy (90%), and 76% of them did so in their first trimester. Only 32% of the young women and 22% of the young men had received either family planning services or information about birth control since they were last surveyed at age 19 (Courtney et al., 2007).

### **Uhlich Children's Advantage Network Study**

The Uhlich Children's Advantage Network (UCAN), in collaboration with The National Campaign to Prevent Teen and Unplanned Pregnancy (National Campaign), conducted a study to better understand the connection between foster care and adolescent pregnancy (Love, McIntosh, Rosst, & Tertzakian, 2005). For this study, focus groups were conducted with foster youth ( $N = 121$ ) and foster parents ( $N = 31$ ), and an online survey was conducted with service providers ( $N = 371$ ). Most foster youth reported that they are able to get information about sexuality and contraception, that birth control is readily available from many sources, including clinics and schools, and that they are able to learn about many contraceptive methods, including condoms, patches, pills, and injections. They also reported that hearing from their peers with direct experience with adolescent parenting can be a powerful way of delivering the prevention message.

The authors concluded that access to contraception does not always mean youth will use it. Youth reported feelings of invincibility regarding the consequences of sex. Many of the youth in the focus groups exhibited a sense of distrust about the effectiveness of contraceptives. In many cases, this distrust seemed to be based upon misunderstandings regarding how contraceptives work and their overall effectiveness. Some youth reported feeling intimidated or embarrassed asking for birth control through a clinic for example, and this has stood in the way of prevention. Youth also said that they face lots of pressures to have sex, and a substantial minority of foster youth appeared not to trust the opposite gender. The study also found that the foster youth often had mixed emotions, which included wanting to continue their education while wanting to establish a family by having a baby (Love et al., 2005).

The study also explored reasons for the failure of the foster care system to more effectively protect youth from early pregnancies and STDs. Although most foster youth reported that they were able to get information about contraception, some indicated that too little information was being offered or that it was offered too late—after they were already sexually active—and that the information was not adequate or consistently delivered. The authors also found that, in addition to information, youth also wanted to talk with and learn more about sex from foster parents, but this rarely happened for a variety of reasons, including embarrassment, the foster parents not bringing up the

subject, and a lack of trust in the foster parents. Many foster youth also expressed a desire for more personal attention from caseworkers around these issues (Love et al., 2005).

In the online survey, 59% of providers working in programs serving youth in foster care said that their program did not have a specific plan for adolescent pregnancy prevention and that staff reported often feeling unprepared to address the issue. Even in programs for pregnant and parenting adolescents, a substantial portion of staff (37%) reported that their program did not have a specific plan to assist adolescents in avoiding a subsequent pregnancy. Fifty-eight percent of providers said that they had not received sufficient training to work with adolescents or caregivers on preventing adolescent pregnancy, including 43% of staff in programs for pregnant and parenting youth. Despite the lack of a clear program strategy and sufficient training, three-fourths of staff working with youth reported talking about pregnancy prevention with their clients, and over 80% of staff working with pregnant and parenting adolescents said they directly address issues of subsequent pregnancy prevention. Many providers said that ensuring adequate knowledge about sex, contraception, and healthy relationships was critical for foster youth. Other providers emphasized the importance of educating foster youth about relationship skills and sexual responsibility. An emphasis on teaching abstinence as the only 100% successful method of pregnancy prevention was reported by a number of providers. Providers indicated that they needed more training to talk with and educate youth on sexuality and healthy relationships. Providers believed and youth agreed that such discussions with staff were needed. Open respectful discussions were viewed as critical by youth and providers, who believed that simply providing information on contraception was not likely to be effective (Love et al., 2005).

### **Current Study**

The two large studies discussed above together present a compelling picture of the extensive and often unmet sexual and reproductive health needs of foster and transitioning youth. Both studies were conducted in the Midwest, however, and it is unclear to what extent these results can be generalized to California's immense and diverse foster youth population, and unique county-based systems of care. To better understand how these findings might apply to California, and to bring the issue of foster youth's sexual and reproductive health into focus for the California Connected by 25 (CC25) Initiative, the Walter S. Johnson Foundation contracted with the Center for Research on Adolescent Health and Development at the Public Health Institute to conduct a sex education and reproductive health needs assessment for foster and transitioning youth in three California counties. The needs assessment was designed to answer the following four research questions in regard to foster and transitioning youth aged 14 to 21 years:

1. What are the sexual and reproductive health needs and challenges of foster and transitioning youth?
2. What barriers stand in the way of addressing these needs and challenges?
3. What suggestions do staff and former foster youth have regarding these needs, challenges, and barriers?
4. What should be done to promote foster and transitioning youth's sexual and reproductive health and to address the issues and challenges that these youth face?

## METHODS

The aim of this study was to assess the need for and the provision of sex education and reproductive health services among foster and transitioning youth in three California counties that participate in the CC25 Initiative. The CC25 Initiative is a youth transitions reform initiative that targets foster youth ages 14 to 24 years and includes both youth in supervised placements and former foster youth ages 18 to 24 years. The purpose of the CC25 Initiative is to develop a comprehensive, integrated continuum of services supporting positive youth development and successful foster care transition to adulthood.

For this study, Fresno, Orange, and San Francisco counties were selected to represent the Central urban and rural, Southern urban, and Northern urban regions of the state. The primary aims of the study were to provide in-depth descriptive information about the sex education and reproductive health needs of foster and transitioning youth, and recommendations on how counties can improve the provision of these services to foster youth in general and to transitioning-age foster youth in particular.

The first step of the study involved identifying and reviewing existing research on the need for and the provision of sex education and reproductive health services among foster youth in California and in other states. In addition, available sex education and reproductive health curricula for foster youth were identified, and subsequently reviewed.<sup>2</sup> Furthermore, researchers who have been involved in supporting or studying the CC25 Initiative were interviewed to obtain contextual information needed to conduct the study.<sup>3</sup>

The project manager for the CC25 Initiative e-mailed a study introduction to the director of the Department of Children and Family Services (CFS) in each of the three counties, describing the study and inviting the county to participate. Once the county agreed to participate, the study staff scheduled a telephone call with the CFS director in each county to answer questions about the study, discuss study logistics, and determine the agency point person for data collection. Given that transitioning-age foster youth are served by independent living programs (ILP) in the three counties we examined, ILP was a major focus of the study.

To address the research questions, various data were collected in the three counties using surveys, interviews, and focus groups. The study procedures and data collection techniques varied across the three counties only to the degree that was necessary to compensate for the difference in the structure of the counties' foster care delivery system. For example, in Fresno County, CFS maintains its own ILP. In Orange and San Francisco County, these services are contracted out to a community-based organization (CBO). Therefore, it was necessary to adjust data collection slightly to include both the CFS- and the CBO-based ILPs.

### Data Collection Instruments

Data were collected through a variety of instruments designed for each participant role, discussed below, and were used for a participant or group of participants in that role in each of the three counties. Many of the instruments used in this study were informed by the previous work and instruments developed by Love and colleagues (2005).

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<sup>2</sup> A review of available curricula that have been cited in the literature as appropriate for foster youth is provided in Appendix A.

<sup>3</sup> We interviewed Heidi Sommer of UC Berkeley's Goldman School of Public Policy, and Tara Lain, representing Dr. Barbara Needell, of the Center for Social Services Research at UC Berkeley.



The data collection instruments included interview protocols for the CFS director, the CFS manager of ILP, the CBO managers of ILP, public health nurses, community-based providers of ILP and other services, and foster parents. The instruments also included web-based surveys of CFS social workers. In addition, a paper-and-pencil survey was designed for the ILP caseworkers (same protocol for both CFS and CBO) who participated in the focus groups. Finally, focus group protocols were developed for ILP caseworkers (same protocol for both CFS and CBO) and for former foster youth. Prior to use, the instruments were reviewed by the three research team members and modified as appropriate. In addition, feedback on the interview protocol for the CFS director was obtained from a former CFS county director.

## **Study Participants**

Recruitment of study participants and data collection strategies varied according to participant roles.

Staff and foster parent interviews. After they were identified in the initial logistics call, we contacted CFS and CBO staff, including directors, program directors, and public health nurses directly by telephone to schedule an interview. These telephone interviews lasted approximately 30-45 minutes.

An agency point person assisted with the recruitment of foster parents; that person contacted foster parents who care for youth, identified foster parents who were interested in participating, and provided us with their names and telephone numbers. We then contacted the foster parents directly to schedule a time for the interview. These telephone interviews lasted approximately 20-30 minutes.

Prior to each telephone interview, participants were read a consent form and were asked to indicate their agreement with and understanding of the consent form.

CFS social worker web surveys. We recruited CFS social workers for the web-based survey with the help of an agency point person, who provided the names and e-mail addresses of the social workers who worked primarily with transitioning-age foster youth (ages 14 through 21 years). The web-based survey was conducted using Survey Monkey. We e-mailed an individualized request for participation with the link to the survey directly to the social workers. Prior to completing the survey, social workers were asked to read a consent form; proceeding onto the survey meant the social workers agreed with and understood the consent form. We added a custom ID to each link (e.g., f01 for the first request sent for Fresno County) to allow for follow up of non-responses. One week later, we e-mailed a reminder request to those social workers who did not yet respond. In San Francisco County, we e-mailed a second reminder 2 weeks after the original request. In Fresno County, 12 of the 14 social workers completed the survey. In Orange County, the web-based survey was administered to both CFS social workers with case-carrying responsibilities and CFS social workers with ILP-tracking responsibilities, and 12 of 15 social workers completed the survey. In San Francisco County, 9 of 18 social workers completed the survey.

ILP caseworker focus groups. The ILP caseworker focus group was set up with the help of ILP in each county. The ILP manager or the person charged with this task informed the staff about the focus group and requested their attendance. We provided refreshments for the staff who attended. Prior to the focus groups, staff were asked to read and sign a consent form and to complete a short paper-and-pencil survey that asked many of the same questions as did the CFS social worker web surveys. The ILP caseworker focus groups lasted 1 hour, and two of the three groups were audio recorded.

Former foster youth focus groups. Former foster youth aged 18 years or older were recruited with the help of ILP in each county. The agency person charged with this task spread the word about the focus group—through flyers, orally, or some other way—and followed up with former foster youth who expressed interest in attending. We provided a meal and a \$20 incentive in the form of a Target gift card to youth who attended. Prior to the focus groups, youth were asked to read and sign a consent form. The youth focus groups lasted 1 hour, and two of the three groups were audio recorded.

A total of 99 participants provided data for this study, with 34 from Fresno County, 37 from Orange County, and 28 from San Francisco County. Breakdowns by participant role and county are provided in Table 1.

**Table 1. Participant roles.**

	Fresno	Orange	San Francisco	TOTAL
CFS director or program director	1	1	2	4
CFS social worker	12	12	9	33
ILP manager*	1	2	2	5
ILP caseworker*	8	9	8	25
Public health nurse	1	2	2	5
Foster parent	2	2	1	5
Former foster youth	8	9	4	21
Community-based service provider	1	0	0	1
<b>TOTAL</b>	<b>34</b>	<b>37</b>	<b>28</b>	<b>99</b>

\*In Fresno, the ILP manager and ILP caseworkers were employed by CFS. In Orange and San Francisco, the ILP caseworkers were employed by a CBO, and in addition to an ILP manger employed by CFS, a second ILP manager was employed by the CBO where services were delivered.

Although demographic data were not collected from interview and focus group participants, observations at the focus groups suggested that participants approximately represented the racial and ethnic diversity of California service providers and foster youth.

At the end of the web-based surveys, CFS social workers were asked, “How many years have you worked in child welfare?” At the end of the paper-and-pencil survey, ILP caseworkers were asked, “How many years have you worked in this or a related position on behalf of children and families?” Across the three counties, 33 CFS social workers responded to the web-based surveys. Three percent had worked in child welfare for less than 1 year, 24% for 1-3 years, 15% for 4-6 years, and 58% for 7 or more years. Across the three counties, 25 ILP caseworkers completed the paper-and-pencil survey prior to their focus group. Eight percent had worked in this or a related position on behalf of children and families for less than 1 year, 40% for 1-3 years, 12% for 4-6 years, and 40% for 7 years or more.

## Data Analyses

This study employed a multiple-case-study methodology (Yin, 2003a, 2003b) across the three counties. Data collected from interviews, surveys, and focus groups were analyzed by county with each county treated as a separate case. Data also were compared across counties, and

similarities across counties are noted. Converging evidence to address the research questions was sought across participant role and county.

Quantitative analyses were conducted on the web-based and pencil-and-paper surveys. Cross-tabulations were performed to display results by county and participant role. Categories were collapsed as appropriate when cell sizes were too small to be meaningful.

Qualitative data from telephone interviews and focus groups as well as write-in comments on the web-based and paper-and-pencil surveys were coded for common themes. The coded qualitative data were copied into a master document under theme headings and organized into tables as appropriate to illuminate commonalities and differences in responding across the three counties and participant roles.

## RESULTS

Study results are organized by research question. As applicable, results from interviews, surveys (both web-based and paper-and-pencil), and focus groups are reported for each research question. Results from former foster youth are identified as from “youth.” To preserve confidentiality, the counties are identified only as County A, B, and C. Quotes from administrators, public health nurses, and CFS and ILP staff are often identified generically as from “staff.”

### **Research Question 1. What are the sexual and reproductive health needs and challenges of foster and transitioning youth?**

In this section, findings are presented on the sexual and reproductive health challenges of foster and transitioning youth. Twelve challenges emerged, as described below.

#### **1. Adolescent pregnancy is largely accepted in the youth’s families of origin and by their peers.**

Staff across two of the three counties emphasized that foster youth grow up in families and within a peer culture that have largely accepted adolescent pregnancy. According to these staff, prevention of adolescent pregnancy thus goes beyond providing information on contraception, but rather, it requires a new familial and cultural expectation, that it is better to delay pregnancy until full adulthood.

*Multi-generation families involved with our agency increases the chances—what they have learned from their families of origin—that compounds foster care youthful pregnancies.*

*Peers, the culture we are up against; teen pregnancy has unfortunately been accepted in their culture; it’s difficult trying to change that perception...ILP is not enough; it takes a village to prevent teen pregnancy, from schools to churches to neighborhood stores.*

Some youth had a similar perception (e.g., “Some teens have kids just because they see other people having kids”).

Going beyond the acceptance of adolescent sex and pregnancy, peer pressure was also seen as important by some staff (e.g., “Being an adult working with youth you are fighting against peer information and pressure. Youth get heckled by peers and have a greater propensity to get an STD.”).

Yet staff noted that peer influences can also be positive, particularly when peers share their experiences with parenting and STDs in the context of a workshop (discussed further in the participant suggestions section).

#### **2. Foster youth often have intense unmet needs for love and a sense of belonging.**

Across all counties and roles, reasons frequently given for foster youth having sex included such love and belonging motivations as “to fill a void,” “fulfill a need to have a family,” and “to have a child to get unconditional love.” Youth across all three counties stated the importance of this issue.

*To feel that I can hold someone, that is a big reason. To make you feel whole.*

*They want to create a family they never had when they were younger. It's not a good idea. You are still a kid trying to raise a kid.*

*Girls in the system have kids really young. Some girls who did not have a father figure are targets, and guys take advantage of that and get them pregnant very young.*

Staff emphasized the importance of this issue. For example:

*Teens might get pregnant because they need somebody to love. When they are in foster care they are removed from their parents, their family. Having a kid is sometimes the person who they can love and love them back unconditionally. So educating on teen pregnancy needs to be holistic...all those issues need to be addressed.*

Youth believed that because many foster youth come into the system with a history of sexual abuse, they are at an increased risk for early pregnancy. For example:

*Over the weekend there was this conference and they had a code of conduct for it against drugs and sex and stuff. And this girl I met said she had sex there with someone she just met and he nudded [ejaculated] in her and didn't have a condom. She said she did it because she grew up molested.*

Staff shared this view, for example: "Many of the youth were sexually abused, they look for love in the wrong places. Promoting abstinence only—not useful—sexually abused kids are going to do it anyway."

### **3. Foster youth sometimes become pregnant to try to hold onto a partner.**

Youth across all three counties suggested that pregnancy can be the result of a youth's desire to hold onto a partner:

*Someone told my girlfriend to get pregnant so I don't dump her and keep me to herself. Girls use babies as leverage, but sometimes it might backfire because I wouldn't be with her. Is that fair on the baby? No.*

*By getting pregnant a young woman thinks it will hold the boyfriend, but it doesn't work, but it's his fault too.*

*Or they want to be with a person so they make a baby to keep that person. So even if they were taught right in their life they think the person will be with them if they have a baby with them. But they don't realize that having a baby doesn't keep you together. I have friends who thought like that.*

One staff also mentioned a desire to hold a partner as an incentive for pregnancy among some youth: "And some of the youth get pregnant to keep the boyfriend."

### **4. School-based sex education is not always available or known.**

For youth who are too young or who choose not to participate in ILP, the only formal sex education potentially available is through the public high schools. Although high schools are viewed as the source of basic sex education, in the words of an ILP staff member, "a lot of school districts don't teach it, especially where they need it the most." CFS social workers and ILP caseworkers were

not always aware of what sex education, if any, was offered by individual schools. “[We could] develop a relationship with the schools to find out what they are offering,” suggested one staff member.

Staff explained that when high school sex education is offered, foster youth might not have the opportunity to participate. With the changes in placement that foster youth can experience, a youth may miss high school sex education entirely, depending on whether the youth attends a given high school during the month that sex education is offered there. In addition, staff reported that faith-based group homes and foster parents may not sign the permission form required for youth to participate in high school sex education. In sum, although some foster youth receive comprehensive sex education through their high school, other foster youth receive little or none.

### **5. Not all foster youth obtain sex education through ILP.**

We sought statistical information on the following three questions about foster youth aged 14-21 years in the three study counties:

- Total number of foster youth
- Percentage of total who participate in ILP
- Percentage of total who attend a sex education workshop while participating in ILP

Across the three study counties, administrators were not consistently able to provide data on these questions. Data across the three counties pertaining to these questions may be available at a later point through the Center for Social Services Research at UC Berkeley, where under the leadership of Dr. Barbara Needell a data system has been developed and implemented for collecting statistical information from counties with CC25 Initiative grants. At present it is not possible to estimate the percentage of youth in each county who attend ILP workshops. It is clear, however, that not all foster youth attend ILP workshops, as not all youth participate in ILP, sex education workshops are not required for youth who participate in ILP, and ILP sex education workshops are not offered continuously throughout the year.

### **6. Having knowledge does not imply using this knowledge.**

Youth across two counties agreed that having knowledge of protection and using it are two separate issues, for example:

*There is enough info, but they don't put it to use or take it seriously...they'll listen, but it goes in one ear and out the other...youth need to take that step and use that condom.*

*I don't want to remember to take birth control.*

Staff at one of these counties agreed: “Kids do have the knowledge, but it depends on how they apply the knowledge.”

Denial of the consequences of unprotected sex was cited by youth as one strong disincentive to using protection. As one youth said, most feel that “it won't happen to me.” A staff person agreed that denial was prevalent: “A barrier is how to engage teens in the knowledge of the consequences of being sexually active.” Denial included not admitting to oneself—in time to plan for protection—that sex was going to happen, as one youth admonished: “Even if you're not in love, you may have sex anyway, prepare yourself.”

A lack of assertiveness in relationships was also cited by youth as a major challenge to protecting oneself. Across counties, youth commented:

*It again depends on the person, because I might have the info, and go to all of the classes, but be too nervous to talk about it with a partner.*

*The girls are afraid to ask their partners to use condoms.*

*Some women have issues being assertive. It's not acceptable to be assertive in a sexual scene. I can't say 'No glove no love.'*

Other possible reasons cited by participants for having unprotected sex include a lack of long-term goals other than becoming a parent, and living totally in the moment without considering the future.

### **7. Absence of consistent, supportive, and trusted adult to talk with.**

Staff explained that foster youth suffer due to a lack of consistent one-on-one support from a caring adult in many life domains, and the highly personal and emotional topic of sex makes one-on-one support all the more important. In the words of one staff member: "A significant barrier is the lack of a caring, trusting adult in whom the youth may confide or discuss such [sex-related] issues without judgment and/or embarrassment." Another staff at a different county believed similarly: "Addressing pregnancy and disease prevention on the surface won't do it because the underlying issues are still there. Youth need long-term relationships with caring adults who can offer support over time, and provide sex education in the context of a relationship." In the absence of permanency, youth's options for discussing sex-related issues with a trusted adult are presently limited and insufficient.

#### Talking about sex with foster parents.

Youth at all three counties expressed disappointment about not being able to discuss the issue of sex with foster parents. A variety of reasons for this were expressed, as shown in Table 2. The most prominent reasons were youth's reluctance to bring up the subject with foster parents, combined with fear of negative consequences if they admitted being sexually active.

Foster parents agreed that it is difficult for youth to talk with foster parents about sex. One foster parent said, "My foster daughter was embarrassed because peers were saying she was easy because she has had many boyfriends."

#### Talking about sex with CFS social workers.

Results of a web-based survey conducted with CFS social workers suggest that they do talk with youth on ways to prevent STDs and pregnancy/fathering a child. These conversations do not occur consistently, however. Overall, 23% of social workers reported often (rather than sometimes, occasionally, or never) discussing these topics with males, and 34% reported often discussing these topics with females, as shown in Table 3.

In addition to how often prevention topics are raised, we asked CFS social workers a second question to assess the percentage of youth on their caseloads with whom they discussed these issues. Overall, only about a third reported discussing prevention issues with half or more of the youth they serve (see Table 4).

**Table 2. Reasons foster youth may not get to discuss sexuality issues with foster parents.**

County A	County B	County C
<p><i>None of my foster parents—I had 14 placements—ever brought up the issue; they were able to establish a curfew and don’t do this and don’t do that, but never a sit down, one-on-one talk.</i></p>	<p><i>Foster parents should take the initiative—break the ice—as it is hard to bring this up with a foster parent, especially if you are in a new foster home when you are going into high school.</i></p> <p><i>My foster parents were from a different culture; it was very hard to bring this up.</i></p> <p><i>Foster parents are seen as ‘transitional and conditional’—I have seen youth kicked out for admitting being sexually active or transgender. There is a fear of getting kicked out.</i></p> <p><i>If there is a biological child in the foster home, the foster parents will fear that the foster will “rotten” the biological child. So I was afraid to let them know I was sexually active.</i></p>	<p><i>Some people think they (foster youth) don’t want to just speak up about it, but someone might be waiting for someone to ask.</i></p> <p><i>People, they feel like—it’s not their [the foster parent’s] business....I’m not going to go to my foster mom and tell her that I am going to have sex. But out of nowhere she said ‘shouldn’t we be able to talk about this?’ and I told her ‘yeah I have.’ And she asked if I was being safe and it let me know I could have gone to her. She brought it up at a strange time—6am in a Laundromat.</i></p>

**Table 3. Percentage of CFS social workers (N = 32) who often talk with youth on ways to prevent STDs and pregnancy/fathering a child.**

	% of social workers	
	Male youth	Female youth
County A	36	42
County B	8	17
County C	25	50
<b>Overall</b>	<b>23</b>	<b>34</b>

**Table 4. Percentage of CFS social workers (N = 32) who generally discuss prevention issues with half or more of the youth on their caseload.**

	% of social workers	
	Male youth	Female youth
County A	42	42
County B	25	25
County C	38	50
<b>Overall</b>	<b>34</b>	<b>38</b>

Youth expressed some discomfort about initiating a conversation about sex with CFS social workers, for example, “Social workers never ever talked with us about sex. I wouldn’t even think about going to the social worker for such discussions.” But on further reflection, this youth offered “there are some social workers I wouldn’t mind asking....” One female youth stated that she would



have felt uncomfortable had her CFS social worker broached a discussion related to sex, “especially because he was male.” The issue of confidentiality also was mentioned when considering discussions with staff: “She [the caseworker] keeps my stuff confidential. This is important to me.”

In one county, a small but important new program matches youth with adult volunteers with whom youth can form long-term relationships, which the county staff view as the best prevention.

**8. When foster youth become pregnant, they do not always get counseling on pregnancy options.**

It is not clear from the data whether youth who get pregnant have access to counseling on pregnancy options. It appears that some are referred to Planned Parenthood or other organizations, and that referrals are sometimes made to CFS public health nurses. Not all youth or staff are satisfied with these resources.

In a web-based survey, CFS social workers and ILP caseworkers were asked who usually provides pregnant foster youth with counseling on pregnancy options. Response options included “I do” (i.e., the CFS or ILP worker), “foster parent or other caregiver,” “someone else,” or “no one I know of” and are summarized in Table 5. Overall, “someone else” was the most common response. A field was provided for write-ins for this response option. The most frequent write-in across counties was Planned Parenthood. Therapists, medical providers, Medi-Cal physicians, CFS public health nurses, teen clinics, and high school wellness centers were also listed.

**Table 5. Person who provides counseling on pregnancy options (percentage).**

		I do	Foster parent/other caregiver	Someone else	No one I know of
County A	CFS	20	20	50	10
	ILP	0	0	75	25
County B	CFS	17	17	50	17
	ILP	56	0	44	0
County C	CFS	0	12	88	0
	ILP	0	50	33	17

Interview comments by administrators on the issue of pregnancy options were fairly consistent. Generally, the staff do not directly address this issue with youth. A response of one administrator was echoed across the three counties: “We provide youth support if they want to go to the doctor or Planned Parenthood. We direct them to the right people. Some youth go though their social workers, some youth do everything on their own.”

Hesitancy about the topic of abortion was expressed across two counties: “The social workers are probably not comfortable discussing pregnancy options. They are probably more directed toward seeking medical attention and prenatal care.” An administrator at another county underscored that staff emphasize prenatal care, not pregnancy counseling, but believed that staff sometimes discuss other options with youth: “Not formally. If a youth is identified as being pregnant, they are

hooked up with prenatal care. But informally, a caseworker would talk with youth about other options.”

Various staff at one county expressed frustration that individualized counseling was not available that took into account the youth’s individual situation and preferences. Some agencies were viewed as counseling all youth to give birth to the baby, whereas others were viewed as counseling all youth to obtain an abortion. “It’s hard to find a place to get unbiased pregnancy counseling. Someone needs to help them find what is best for them.”

**9. Responsibility for connecting pregnant youth with prenatal care is diffuse.**

Across all three counties, it appears that no one person has the responsibility for connecting pregnant youth with prenatal care (see Table 6). People from a variety of roles in each county (including the CFS social worker, ILP caseworker, foster parent or other caregiver, or someone else) usually assist pregnant female foster youth obtain prenatal care. “Foster parent or other caregiver” was the most common response by both CFS social workers and ILP caseworkers.

**Table 6. Person who connects pregnant foster youth with prenatal care (percentage).**

		I do	Foster parent/other caregiver	Someone else	No one I know of
County A	CFS	9	64	27	0
	ILP	12	75	13	0
County B	CFS	17	25	42	17
	ILP	56	22	22	0
County C	CFS	22	67	11	0
	ILP	33	17	33	17

As shown above, ILP caseworkers in Counties B and C generally do not rely on foster parents to help pregnant youth obtain prenatal care. One explained this as because “many of the young women with whom we work are emancipated.”

Across the three counties, CFS and ILP administrators and staff expressed confidence that pregnant foster youth are assisted in obtaining prenatal care, provided that the pregnancy is revealed by the young woman. This response by an administrator was fairly typical: “Nothing written, but there is an informal policy to make sure they get prenatal care and remove barriers. It’s a general social work obligation.” For those youth who are emancipated, Medi-Cal was mentioned as the payer for prenatal care. ILP staff at one site expressed concern that they would feel more reassured that young women make it to the doctor for prenatal care “if somebody went with them.”

An issue raised by staff at two counties was that youth’s fear and discomfort in revealing pregnancy might impair adults’ ability to help provide prenatal care:

*Improvement could come with making the youth more comfortable, so they share that they are pregnant. Need training for staff and parents.*

*I would want to assume 100%, but contingent on knowing...some of the clients hid their pregnancy by losing weight. For everyone who tells us, the [prenatal] services are being provided.*

**10. Staff do not consistently offer subsequent pregnancy prevention information to youth who were pregnant.**

On the issue of helping youth who were pregnant or parenting to prevent another pregnancy, an administrator at one county said that the staff was “absolutely” encouraged to discuss this with youth. An administrator at a second county commented: “I believe so, but it would happen informally. There is no official, written policy on it.” Despite this confidence, only about half of staff reported often (as opposed to sometimes, occasionally, or never) discussing methods of preventing subsequent pregnancy with pregnant (male or female) youth (see Table 7).

**Table 7. Discussion of subsequent pregnancy prevention with male or female youth (percentage).**

		Often	Sometimes	Occasionally	Never
County A	CFS	40	30	20	10
	ILP	25	38	12	25
County B	CFS	40	40	0	20
	ILP	67	33	0	0
County C	CFS	80	0	20	0
	ILP	20	40	20	20

One county’s CFS social worker offered an explanation for subsequent pregnancy prevention not being discussed more consistently. “There is a lack of interest in discussing this issue since the most immediate issue relates to the current pregnancy.” The public health nurse in that county agreed: “Social workers absolutely do not [discuss subsequent pregnancy prevention]. The focus goes on the baby. Social workers don’t have the time to keep up after that.”

A staff member at a second county agreed that youth do not get information on subsequent pregnancy prevention:

*If they decide to keep the pregnancy, they go to the group home for pregnant youth, where they get prenatal care and parenting info....I have confirmed that they don’t provide info about prevention of future pregnancies. They don’t have the resources, they think the kids will smarten up and don’t do this again.*

A foster mother at the third county noted that assumptions are made by adults that having a baby will teach youth the importance of birth control, although this assumption is often not borne out: “The first baby should teach them a lesson not to have more children, but it does not always work that way.”

ILP staff explained that parenting youth, facing many survival challenges, don’t plan ahead for the prevention of subsequent pregnancy, for example, “they [youth] are living week to week and don’t think ahead, or of the future, in terms of pregnancy—both male and female.”

**11. Staff do not consistently discuss preventing subsequent pregnancy with foster parents caring for pregnant youth.**

Despite the key role of foster parents in providing prenatal care, as reported above, the CFS and ILP staff working with pregnant foster youth differed widely by county in their responses to the

question of whether they generally discuss preventing subsequent pregnancy with the youth's foster parents and other caregivers. As shown in Table 8, this ranged from 0% of ILP caseworkers in County C to 100% of CFS social workers in County B.

**Table 8. Percentage of CFS social workers and ILP caseworkers who generally discuss preventing subsequent pregnancy with foster parents/caregivers.**

	CFS*	ILP**
County A	20	25
County B	100	22
County C	60	0
<b>Overall</b>	<b>41</b>	<b>18</b>

\*The six Orange County CFS social workers who worked with emancipated youth were **not** asked this question.

\*\*ILP caseworkers may not be expected to perform this role as they may have little contact with foster parents or they may work primarily with emancipated youth.

**12. ILP caseworkers appear to discuss prevention issues less frequently with male than with female foster youth.**

ILP caseworkers were surveyed to assess the percentage who often or sometimes (as opposed to occasionally or never) discuss a list of issues related to comprehensive sex education with male and female youth. As shown in Table 9, topic overall percentages ranged from 72% for healthy romantic relationships to 12% for IUDs, with variation across sites and gender. For most topics, including healthy romantic relationships, STDs, condoms, and sexual orientation, the staff reported discussing these issues more often with female youth.

**Table 9. Percentage of ILP caseworkers who often or sometimes discuss selected sexuality education topics with foster youth.**

Topic	Average across counties and genders	County A		County B		County C	
		Male	Female	Male	Female	Male	Female
Healthy romantic relationships	72	62	88	78	89	38	75
Raising a child	70	62	88	78	100	25	62
STDs	62	25	75	78	89	38	62
Condoms	60	38	62	89	100	25	38
Sexual orientation	50	38	62	56	78	25	38
Abstinence	48	62	50	33	89	12	38
Birth control pills	37	25	62	12	78	0	38
Abortion	22	12	25	0	67	0	25
Diaphragms	16	12	38	0	22	12	12
Adoption	15	0	0	0	50	12	25
IUDs	12	12	0	0	11	12	38

**Research Question 2. What barriers stand in the way of addressing these needs and challenges?**

In this section, findings are presented on the barriers cited by participants as standing in the way of addressing the sexual and reproductive health needs and challenges of foster and transitioning youth. Four barriers were identified, as described below.

**1. Unclear policies, unclear roles, and liability.**

Across all three counties we heard that the roles of CFS and ILP staff as well as of foster parents in promoting sex education and reproductive health among foster youth are not clearly outlined in formal policies and procedures. In addition to unclear role definitions, another barrier commonly reported was unknown or non-existent policies on liability and parental rights. Youth confidentiality issues are also an issue. Responses across all three counties by CFS and ILP staff are summarized in Table 10.

**Table 10. Policy barriers on roles, liability, parental rights, and confidentiality, as reported by staff.**

County A	County B	County C
<p><i>I would need it to be clear what we can discuss with them, what are the boundaries in talking about services that could be available to them...most of us feel probably feel very comfortable talking about it [the subject matter], but just what parts do we talk about.</i></p> <p><i>It goes back to what the department says I can talk about. I don't know how far we can go into a conversation; I avoid certain topics. Before we identify ourselves as a resource, we need to put in some serious training and some serious protocols if we are going to do this.</i></p> <p><i>I was just thinking that if a kid is in foster care and the child is to reunify with the parents, who are we to talk to their kids about sexuality? A parent might not want their kid to be exposed to it, parents have certain rights. We need to be able to identify what legally when can talk about.</i></p>	<p><i>Policies that prohibit the early discussion of sexuality issues with children and adolescents are a significant barrier to services and resources.</i></p> <p><i>I don't know if the concern about staff talking to the child on this issue and educating them on options is involved with legal barrier, but people are concerned about liabilities. Since we don't have an education program in place, we don't have a policy on how to discuss this topic with youth and how to address it, especially in regard to termination of pregnancy. I would say we could probably do a better job in this area.</i></p>	<p><i>We need a policy that it is okay for the worker to talk with the youth about STDs and pregnancies.</i></p> <p><i>It helps for everyone who interacts with youth—county, ILP agency, schools, etc.—to be on the same page in regard to what youth are provided.</i></p> <p><i>What could be improved? Probably having a formal policy.</i></p>

A foster parent raised similar issues:

*There are political and/or religious views regarding sexuality and birth control that I was concerned about before initiating the conversation with youth. My own view is that we have an obligation to the children to preserve their health.*

A staff member at one county raised the issues of confidentiality of information that might be provided by foster youth if discussions were held on sexual issues:

*Additional training would be helpful, especially in confidentiality law. With sex education, if you want to talk to the youth at their level you need to know what is going on. It's not clear when we do sex education, what the youth can say that is confidential in the foster care system.*

**2. Inadequate communication on sexual risk prevention between CFS social workers and ILP caseworkers, and foster parents and other caregivers.**

Overall, 88% of CFS social workers and 75% of ILP caseworkers reported that they feel very or somewhat comfortable talking with foster parents or other caregivers about ways to help foster youth prevent STDs and pregnancy/fathering a child. Nevertheless as shown in Table 11, the majority of CFS social workers and ILP caseworkers only occasionally or never (as opposed to often or sometimes) talk with foster parents and other caregivers about prevention.

**Table 11. Percentage of CFS social workers and ILP caseworkers who occasionally or never talk with foster parents and other caregivers about prevention.**

	<b>CFS*</b>	<b>ILP**</b>
County A	67	87
County B	83	100
County C	57	83
<b>Overall</b>	<b>68</b>	<b>91</b>

\* The six Orange County CFS social workers who worked with emancipated youth were **not** asked this question.

\*\*ILP caseworkers may not be expected to perform this role as they may have little contact with foster parents or they may work primarily with emancipated youth.

**3. Some CFS social workers and ILP caseworkers believe they are not adequately trained.**

Lack of training in adolescent sexuality was seen as a barrier by approximately one third of the social workers and caseworkers overall. As shown in Table 12, there was considerable variation across counties.

**Table 12. Percentage of CFS social workers and ILP caseworkers who strongly or somewhat disagree with the statement “I have received sufficient training in adolescent sexuality.”**

	<b>CFS</b>	<b>ILP</b>
County A	42	50
County B	25	11
County C	56	25
<b>Overall</b>	<b>39</b>	<b>28</b>

Similarly, about a third of CFS social workers and ILP caseworkers indicated that they had insufficient training in comprehensive sex education, including the prevention of STDs and pregnancy/fathering a child (Table 13). A higher percentage of these staff—about half of CFS social workers and nearly three-quarters of ILP caseworkers—indicated that they have inadequate

training to work effectively on prevention issues with foster parents and other caregivers (Table 14).

**Table 13. Percentage of CFS social workers and ILP caseworkers who strongly or somewhat disagree with the statement “I have received sufficient training in comprehensive sex education, including the prevention of STDs and pregnancy/fathering a child.”**

	CFS	ILP
County A	42	62
County B	25	33
County C	44	12
<b>Overall</b>	<b>36</b>	<b>36</b>

**Table 14. Percentage of CFS social workers and ILP caseworkers who strongly or somewhat disagree with the statement “I have received sufficient training to work effectively with foster parents and other caregivers about how to communicate with adolescent foster youth on the prevention of STDs and pregnancy/fathering a child.”**

	CFS*	ILP**
County A	42	100
County B	50	33
County C	56	87
<b>Overall</b>	<b>48</b>	<b>72</b>

\* The six Orange County CFS social workers who worked with emancipated youth were **not** asked this question.

\*\*ILP caseworkers may not be expected to perform this role as they may have little contact with foster parents or they may work primarily with emancipated youth.

#### 4. Diversity of religious and moral beliefs and values.

Several staff noted that the diversity of religious and moral beliefs and values of staff, foster parents, group home leaders, and the larger community can present a challenge that must be considered and dealt with. Faith-based foster and group homes were cited as examples. Many comments were made across two counties about these issues, as summarized in Table 15.

**Table 15. Diversity of religious and moral beliefs and values, as reported by staff and youth.**

	County A	County B
<b>Staff on discomfort</b>	<p><i>This is the reason I didn't ask a pregnant teen whether she was getting prenatal care or any other questions; it was beyond my comfort level; I don't know what they are thinking; I just keep focus on ILP stuff, bus pass, workshops...</i></p> <p><i>I was just pulling things from out of the air because I really didn't know what was available to her. And then she asked if I knew anything about getting an abortion—and my personal opinion is just my personal opinion, but it really impacted what I said to her, because of course I didn't want her to have an abortion.</i></p>	<p><i>The barrier is the staff being uncomfortable in having the discussion with the youth, and their own beliefs, for example, sometimes staff have their own beliefs on abortion. Then we have to reassign someone else to help the girl in terminating the pregnancy, this is hard on the child.</i></p>

**Table 15. Diversity of religious and moral beliefs and values, as reported by staff and youth (continued).**

	County A	County B
<b>Staff on barriers related to placement</b>	<i>Because even to get info from schools you need parent consent; they are not adults, who's giving them consent to get this information?</i>	<i>Foster parents...get the least training. Their moral values do not always allow for them to get involved with sex ed.</i>
<b>Staff on barriers related to group homes</b>	<i>I know that group homes...lock them [condoms] up.  It [locking up condoms] is a common practice.</i>	<i>Faith-based group homes only teach abstinence. Other group homes are reluctant—we cannot take the youth for birth control unless we get permission of the staff. Most group homes don't adequately address sex ed.  The group homes don't want to 'teach them any sexual behaviors.'</i>
<b>Youth on barriers</b>	<i>My foster parents were very religious and told me not to have sex, that it's a sin and I'd go to hell.</i>	<i>The placement I was at, a group home, some staff did not want to sign for high school permission to get sex ed.  The caregivers in group homes aren't comfortable with sex ed information and resources. Staff are afraid people will go crazy if we provide condoms....No one wants to be responsible for 'promoting' something.</i>

**Research Question 3: What suggestions do staff and former foster youth have regarding these needs, challenges, and barriers?**

In this section, findings are presented on the suggestions of staff and former foster youth. Ten suggestions are discussed below.

**1. Sex education should be provided through ongoing group presentations.**

Staff and youth strongly suggested that ongoing group presentations should be established. These presentations should be open to youth prior to the age at which they became eligible for ILP services. Presentations should include graphic information on STDs, as well as how to use condoms, and “what to do after the fact.”

As illustrated by the examples in Table 16, staff at the three counties consistently recommended more group presentations.

**Table 16. The need for group presentations on sex education for foster youth, as reported by staff.**

County A	County B	County C
<i>They need more group education (even males and females separately), to drill down on the issues. Need ongoing education, goal setting, positive reinforcement...would do better if they had such individual attention.</i>	<i>More exposure and opportunity to learn about prevention and what to do after the fact, to know where the resources are.  Would like to do more frequent workshops around that theme and get more youth to participate, that would loosen them up to reach out for help from the resources that are identified at those workshops.</i>	<i>Classes to give them a chance to reflect and understand that others are getting the same information.</i>



A youth underscored this view: “There should be more education. It has just been the general sex education and there is a lot more and most people have an issue and can’t talk about that.”

Specific suggestions for enhancing group presentations included the following:

- Making attendance mandatory for all ILP participants (staff at two counties)
- Identifying and hiring more engaging, professional workshop speakers (staff at two counties)
- Including training on handling emotional and intimate relationships (staff at one county) and the role of sex in a healthy relationship (staff at a second county)
- Including small group discussions (staff at one county)
- Having separate groups for males and females (staff at one county)
- Including a workshop component to discourage sexual relations in addition to components on protection methods (staff at two counties)

**2. Sex Education should start earlier.**

Across the three counties, staff recommended that group presentations and other forms of sex education need to start earlier and prior to ILP eligibility, with younger foster youth. Staff comments are summarized in Table 17.

**Table 17. When sex education should start, as reported by staff.**

County A	County B	County C
<p><i>Very early education. Setting up a safe atmosphere, to make up for the loss of continuity in care a lot of youth experience.</i></p> <p><i>Talking with youth about responsibility of bringing a new life into the world, and starting when the youth are much younger.</i></p> <p><i>Need to start at an earlier age for foster youth than is now being provided—before ILP eligibility.</i></p>	<p><i>Need to start at an earlier age for foster youth than is now being provided—before ILP eligibility.</i></p>	<p><i>On the ILP side, to see these things are built into the curriculum. Build that [pregnancy and STD prevention] in very early as part of ILS, hold workshops.</i></p> <p><i>Some youth are already sexually active when they come to programs.</i></p>

Foster mothers at two counties also believed that sex education and discussion should begin at earlier ages, suggesting “early education, early discussion,” “for girls, maybe when they start talking about boys,” “start talking at 7<sup>th</sup> grade.” A youth expressed a similar view: “Kids have to be 16 to take ILP classes, so what about the 13-year-olds who are already having feelings, already having sex, going through puberty and they don’t know anything, but they want to have sex. Classes need to be earlier.”

**3. Sex education should include peer-to-peer components.**

Staff at one county suggested peer-to-peer presentations: “Bring in a teen that is parenting to talk to the youth, peer to peer, and having a training component after that.” A staff member in a different role at that county believed that sex education, when powerful and relevant, would be passed on to other youth in the community peer to peer:

*I remember a workshop in another area when someone with HIV came and talked about their own experiences, that was very powerful. Also thinking about their need for morning after pills, signs of symptoms of STDs, going for HIV tests when they have multiple partners, the very basic stuff. Kids talk to each other a lot about these things, so if we got some kids informed, they would talk with one another in their own circle of friends.*

A foster parent at one county made a similar suggestion:

*Being exposed to others who have made choices to be a teen mom or have a teen pregnancy, and the difficulties that life presents....Exposure to teens who have been there to share their difficulties, and their successes.*

And youth across two counties strongly promoted peer-to-peer education:

*Peers are believable because they are doing it [having sex]; same for teachers....Peers are going through the same things so they are believable.*

*Teens feel comfortable learning from other teens.*

*Seeing what's going on with friends, very hands on, seeing others getting pregnant and getting STDs, hearing stories from different people.*

#### **4. More compelling information on the dangers of STDs should be provided to foster youth.**

Youth at two counties argued that information on the dangers of STDs should be graphic, for example, "Info from Planned Parenthood is helpful because they actually break it down for you, show you pictures," "The pictures of people dying from herpes and syphilis." They felt that this would help youth overcome denial and get their full attention. A foster parent at one of these counties had the same recommendation for "graphic information."

Providing youth with evidence on STD and HIV infection rates in their own immediate communities was recommended as a powerful educational component by the youth at one county. For example:

*They should do a documentary in the area and give information on STD and HIV in different communities. Maybe in certain places more people will have HIV. That will get youth to think about making the right choice to not have sex.*

*We went to [an alternative high school]. Everyone had to have an STD check before they went to that school and 80% had an STD, and one person tested positive for HIV. Everyone was thinking 'don't drink out of my cup and who has it?' This really opened my eyes.*

#### **5. Youth should be trained on how to use condoms.**

Staff at two counties made these suggestions:

*We [CBO] bring in a box containing various contraceptives, like condoms, so youth can see them and touch them and understand how to use them.*

*We should have them practice putting on a condom with a plastic penis, it will come up in their life.*

## **6. Youth should have the opportunity for frequent one-on-one discussions on sex-related issues with trusted adults.**

Suggestions for one-on-one discussions were made by participants across counties and roles. Both staff and youth stated that youth should have the opportunity to have open and honest sex-related discussions with trusted adults in a safe environment, and that these conversations should happen with sufficient frequency to normalize talking about sex. To achieve this, various staff across counties suggested that sex education should be a routine topic of conversation between youth and social workers.

Staff at two counties explained their beliefs that youth having such conversations with people with whom they have long-term relationships is even more important than workshops:

*In general, youth benefit from long-term, stable healthy relationships. However you can get an adult to act as a parent to whom they can be accountable. Workshops are good but the real answer is people in their lives. Focus on staff and volunteers in more one-on-one relationships with youth. Strong relationships are the best prevention key. Find more ways to do that.*

*The strategy we use, the direct, one-on-one connection works best in preventing pregnancies and STDs. Youth learn a little bit from workshops, but talking with individuals about their plans and futures works best.*

Staff and youth stated that in addition to providing information, the goal of such conversations is to reduce the fear of discussion, and to normalize and demystify adolescent sexuality education. This will help youth speak more openly about sexual activity, ask questions, think more clearly on sex and its consequences, and plan for protection, accessing resources when needed.

A staff member at one county suggested that the social worker should assume this trusted-adult communications role (“The social worker should ask them one-on-one if they are sexually active”), and another staff member recommended creating a common protocol to standardize this sexual health communications practice:

*I think one area of improvement would be to standardize the practice to make sure the social workers are asking the right kinds of questions and making it easier for them to refer the kids for consultation. Making it into a standard protocol that could be issues to all social workers, not just the unit specifically dedicated to working with teens.*

A staff member at a second county believed that youth presently feel unsafe discussing these issues, with a proposed solution: “Discussing the issues regularly would create an environment of safety for youth. Sex is a natural phenomenon when you discuss these topics.” At a third county, three staff members, each with a different role, also emphasized normalizing the issue by addressing sexuality issues regularly with all youth.

*Discuss dating relationships at every meeting. Ask direct questions about sex and safety. Offer to take them to the clinic to get birth control. Make it a normal conversation, part of ‘normal’ social work practice.*

*We try to engage the youth in conversation that tries to remove stigma and shame from pregnancy to contracting HIV or STDs. We try to normalize the topic.*

*The issue should be normalized...whether or not someone looks like they are having sex...some of the quietest youth are still having sex, and it's easy to forget about them.*

In regard to speaking with staff about sexuality issues, a youth also expressed the issue of fear: "There is a fear of not being able to talk about it; youth want to feel secure."

Youth across two counties recommended the same solution as staff did.

*Start talking with youth when they are young so they get used to it, like it's a normal thing to discuss...some youth might think that sex is too personal to talk about, so they keep it to themselves.*

*[Social workers should] make it part of a routine. Ask each youth if they know about sex ed. Put a sex ed sheet in each youth's case file. What does this person know about pregnancy prevention, STDs, and resources?*

As summarized in Table 18, youth across all three counties stated that youth should have the opportunity to have open, honest interactions in a safe environment with foster parents or caregivers in other types of placements.

**Table 18. Youth want the opportunity to discuss sex with foster parents, as reported by youth.**

County A	County B	County C
<p><i>And a lot of foster parents don't talk about it because it's not their kids. Kids have questions and if foster parents really want to talk with them, kids will listen.</i></p>	<p><i>Should get foster parents to be okay with sex at a young age and try to protect them; show them all options.</i></p>	<p><i>Be more in their life, or take them to sex ed classes and talk to them. Take them to workshops with their foster child.</i></p> <p><i>A lot of foster parents just want to get a check and didn't want to take the time of day to take you to the clinic. I don't know if they should put it in the job description that they have to do it.</i></p> <p><i>Sit down and talk to them. I'm not trying to be in your business but get the information. My [foster] mom said that she was going to take me to the clinic and get me on birth control pills when I was in a long relationship.</i></p>

A staff member suggested that when available, mentors or other adults with whom the youth has been connected as part of a permanency plan would potentially also have an important role in normalizing discussions of sex and sexual health. This approach will become more feasible as programs increase their emphasis on helping youth build long-term relationships with trusted adults as part of permanency planning.

**7. Foster parents, social workers, and caseworkers should receive more training.**

Training for foster parents.

Staff expressed their recommendations that foster parents need training on how to communicate better with youth on sex education issues, as summarized in Table 19.

**Table 19. Foster parents need for more training, as reported by staff.**

County A	County B	County C
<p><i>But there are so many things foster parents need to be trained on, and this is probably the last thing anyone will venture. Having foster parents and group homes take the responsibility is the only way staff can get away from the liability. The reality is in order to be completely safe, it needs to be part of their curriculum.</i></p> <p><i>In the past, I've been sought by foster parents on advice on how to interact with their teens [around sexuality issues].</i></p>	<p><i>More education for foster parents during [when their foster children are in] high school.</i></p> <p><i>Need to educate caregivers of group homes and foster parents or kinship caregivers.</i></p> <p><i>The system could do a better job towards educating caregivers, need to partner with caregivers, say to caregivers, here are some tools.</i></p>	<p><i>With licensed foster parents, they are mandated by the state to get a certain number of hours of training, but we don't mandate the type of training they are to provide.</i></p> <p><i>Biggest barrier is not placing youth in family environment, and the second is not training caretakers to have these conversations. We don't give youth or caretakers an opportunity to have these preventative conversations.</i></p>

Foster parents in two counties expressed similar views on this issue:

*Take a teen sexuality class for parents, get information, if you can't talk with your kids about sex find someone who can. Foster parents are the current parents, and they have to teach the kids in their care. Foster parents should at least take a class about teen sexuality, diseases, communication. I found the classes very useful, because things have changed since I was young. It would be useful if they had a few more classes for foster parents.*

And a foster parent from the third county said the following:

*I think all [foster] parents of teens should be given info on sex education and education on STDs, and birth control. I have not received any info from the county. Has the social worker ever brought this up? No. I had to borrow info from the public school to share with the foster child who didn't know where babies came from.*

Training for CFS social workers.

Participants across roles and counties strongly suggested training for CFS social workers. To underscore the strength of these views, we have detailed the supporting data obtained from the various data collection approaches employed.

a. Web surveys of CFS social workers: Responses to open-ended survey items indicated that CFS social workers across the three counties also desire more training (Table 20).

**Table 20. Percentage of social workers who answered the web survey's open-ended question about ways to improve services for foster youth and whose answers fell in the following two categories.**

	County A	County B	County C
Provide ongoing trainings for all staff	58	50	11
Provide staff with knowledge of resources available to help youth not get pregnant or have another child.	8	33	0

Examples of write-in responses for further training included the following:

*Have staff trained on the topic and not afraid to discuss it with our youth.*

*I think this topic can be very uncomfortable for people. I think staff also need a training on maybe how to approach that with youth.*

*It would be better support to our foster youth by first starting off with providing staff with the proper education and not just assuming that staff are aware of the issues.*

*Provide information on what the school is doing to educate youth.*

*Providing staff with certain tools, such as pamphlets or contacts with specialists, to provide to the youth during discussions on the topics or as issues come up, such as pregnancy and/or an STD situation.*

*Staff need better understanding of what views the youths currently hold about STDs and pregnancy.*

b. Staff interviews and focus groups: Interviews with CFS social workers and ILP caseworkers as well as focus groups with ILP caseworkers elicited similar comments that more training was needed regarding adolescent sexuality, prevention, resources, and engaging youth (Table 21).

**Table 21. Training for CFS social workers and ILP caseworkers, as reported by staff in interviews and focus groups.**

County A	County B	County C
<p><i>Staff need to be trained, there are currently no checks to know the staff level of knowledge and comfort. It's never been part of the social work curriculum.</i></p> <p><i>We need to empower staff to have these very difficult conversations, sometimes social workers are embarrassed. But youth are often embarrassed. Education needs to start with social workers.</i></p> <p><i>For me to be able to guide them when I don't even have the information is very difficult. I would like updated information so we will all know what birth control methods are out there and their reliability, how to keep safe and clean, just really basic things that a lot of people overlook. To sit down with a youth, there needs to be some sort of guideline—this is what is available—so we can share that as accurate information.</i></p> <p><i>Need training in which we role-play social workers and youth...to get us more comfortable doing it on a regular basis.</i></p> <p><i>Just knowing the different services in the community youth can access.</i></p> <p><i>Some of us need to get out of our comfort zone, because we were raised also not to talk about sex to adults.</i></p>	<p><i>We probably could better educate our social workers on the services that are available.</i></p>	<p><i>There needs to be a lot more education in the foster care system about reproductive health...and what youth go through.</i></p> <p><i>[Could use more info on] how to effectively engage youth in seeking resources and services.</i></p> <p><i>There is often a kind of 'unopened door' between a social worker and a teen in terms of reproductive health.</i></p> <p><i>There seem to be no 'natural' opportunities to bring up sex with youth. We only have opportunities to talk to them when there is a problem from sexual activity and the youth bring it up.</i></p> <p><i>We have had no training....Every few years there are always new topics on what STD is current or other new information but we are not getting it. We would like to be updated every year. We need training on how to talk to youth. We need to know how to dialogue with youth on emotional issues connected to prevention....We need facts and figures to help us understand the problem and to use it our efforts of STD prevention....We don't know how to talk about relationships and planning around prevention.</i></p>

**8. Foster youth gender issues should be better addressed.**

Male resistance to condoms needs to be addressed, as raised by youth across two counties:

*Most guys don't like condoms.*

*They think if they don't use protection it feels better. Or they are allergic to condoms/latex.*

Staff at one county believe that male youth specifically perceive that they have different [lower] level of responsibility with female pregnancy. A relative scarcity of male social workers and caseworkers may exacerbate staff difficulties in discussing condom issues with male youth.

Female youth expressed a desire for a more customized approach, including one-on-one support in choosing the right protection for themselves. Some agencies want youth to use only condoms, others emphasize “the shot” for birth control. Youth want to make these choices for themselves. Table 22 summarizes comments made by female youth at two counties.

**Table 22. Female youth need for a more customized approach to sex education, as reported by youth.**

County A	County B
<p><i>Some birth control will not work for one person, but it will work with another person.</i></p>	<p><i>When I was in foster care, I was allowed to use condoms but not 'female birth control.' I wanted to use both, but it was against their traditions to use female birth control.</i></p> <p><i>They just gave me the shot, I didn't know the options. We really have to work to get the information.</i></p> <p><i>Youth should be asked, What do you want, and need? Some youth are pressured to have a shot. We need background support. Need to know more about sexual health. Youth need to have a voice, and not just be pushed around.</i></p>

Staff across the three counties also stated that more info is needed by lesbian/gay/transgendered youth (Table 23). A youth reinforced this need: “When it comes to sex ed it shouldn't be only thought of as man and woman.”

**Table 23. More information is needed by lesbian, gay, and transgendered youth, as reported by staff.**

County A	County B	County C
<p><i>At the lesbian/gay/transgendered group we had a PH nurse come to talk to the youth. Youth said that was the first time they had someone with a medical background talking with them about same-gender sex. There is great need on education about sexuality in same-gender couples. It's not out there, I don't even know if Planned Parenthood has it.</i></p>	<p><i>Some of the boys are unsure of their sexuality. There is not much [health] support for gay promiscuous youth.</i></p>	<p><i>The program should make sure the staff is cohesive and open to diversity in sexualities.</i></p>

**9. Information and resources should be more accessible, including free condoms.**

As shown in Table 24, both staff and youth at different counties stated that information and resources should be integrated on-site with other programs for foster youth, for example, as part of an ILP facility.

**Table 24. Staff and youth recommendations for on-site integration of information and resources.**

	<b>County A</b>	<b>County B</b>	<b>County C</b>
<b>Staff</b>	<p><i>Access to a clinic on-site is amazing for the youth.</i></p> <p><i>Have birth control on-site, have info on services to give you as to where to get an abortion, where to get condoms. It's a task for some of the youth to go to these services, so maybe having a representative like from Planned Parenthood on a regular basis, that way there is someone on-site so the youth don't have to go off-site.</i></p>	<p><i>Would be good to have a clinic on-site, where experts can provide information. We have that to some degree, and they have a nurse who is part of the department. We currently refer youth to community-based clinics.</i></p>	
<b>Youth</b>			<p><i>Youth should know there are places to get education and resources for free. They should not just be told, 'Go to Planned Parenthood!'</i></p>

Across the three counties, staff and youth also recommended distributing free condoms to foster youth as an essential resource needed to translate knowledge into protection (Table 25).

Yet how to implement free condom distribution offers its own challenges, as evidenced by staff and youth comments. Staff at one county spoke of the rapid disappearance of condoms if available to youth in bulk. "We took the bowl of condoms out of the resource room and now youth must ask an ILP coach for them. Otherwise the contents of the entire bowl would sometimes disappear in one day." A youth at a second county made a similar comment: "At the city college, they give out condoms on a couple of days...someone stole a whole box."

One youth doubted the quality of the free condoms available: "The Planned Parenthood condoms are cheap and don't work. I want to use a condom that is a well-known name brand."



**Table 25. Staff and youth suggestions for free condoms.**

	<b>County A</b>	<b>County B</b>	<b>County C</b>
<b>Staff</b>	<p><i>Many foster youth rely on foster parents or group homes to take them wherever they need to be, so how are they going to go forward and say, by the way can you take me to the clinic so I can go get condoms? That's unheard of, we wouldn't even do that with our own parents, much less doing it with someone who is getting paid to take care of us—the trust just isn't there. This is not in all cases, but in many cases. So having someone on-site, where youth can come on their own—and it's confidential—and get the services they need.</i></p> <p><i>Group homes locking up condoms is a common practice.</i></p>	<p><i>They are teens, they think they are invincible. There is a lack of education; they have no access to resources. We can talk to them all day, but they don't know where to get the condoms, that is the problem. I think we should be a lot more open, we should have regular info for them, we should have condoms for all foster youth. They need to have both info and resources regularly available to them. Especially condoms, we bought \$1 million of condoms [in another country] and we would distribute them everywhere where we thought that kids without resources would be, like to the grocery store with their foster parents.</i></p>	<p><i>Give them free condoms.</i></p>
<b>Youth</b>	<p><i>Lots of centers give out condoms, like Planned Parenthood. It would be great if ILP started giving out condoms. When youth pick up bus passes, ILP could encourage them to pick up a condom. Young people, former foster youth, aren't going to go spend \$7 for a pack of condoms...they try to get them for free.</i></p> <p><i>Caseworkers should definitely ask kids if they are sexually active. If they say yes, give them condoms. Because just telling them don't do it, but giving them nothing, is just like turning their backs. Talking about it is not enough.</i></p>	<p><i>I can't afford condoms.</i></p>	

**10. Pregnant youth should receive additional services.**

As discussed above, responsibility for providing pregnant youth with pregnancy counseling and prenatal care, as well as the prevention of subsequent pregnancy, is diffused within and across counties. Adults in a variety of positions (including the foster parent, social workers and caseworkers, and other staff at other agencies) are assumed to be meeting the needs of youth. Staff across two counties offered specific suggestions:

*Provide more mentoring programs that offer options at the beginning of the pregnancy, which will focus on choices and best judgment.*

*At this group home for pregnant females, they need info, sex will come up again, the education component is a big one that is missing.*

**Research Question 4: What should be done to promote foster and transitioning youth's sexual and reproductive health and to address the issues and challenges that these youth face?**

This question is addressed by the recommendations in the following section.

## SUMMARY AND RECOMMENDATIONS

### Summary

This study provides an in-depth description of the sexual and reproductive health needs of foster and transitioning youth in three California CC25 Initiative counties. Based on a mixed-methods study, involving interviews, focus groups, and surveys of staff, former foster youth, and foster parents, we have identified three key themes. These themes relate to the sexual and reproductive health needs and challenges of foster youth, barriers to addressing these needs and challenges, and suggestions from the participants regarding these needs, challenges, and barriers. In this section, we briefly summarize these themes and then provide nine specific recommendations derived directly from these results.

#### **Theme 1: Sexual and reproductive health needs and challenges of foster youth.**

Our findings reinforce the belief that foster and transitioning youth face substantial sexual and reproductive health challenges. These challenges include the acceptance of early pregnancy in their families of origin and by their peers, a stronger longing for love and a sense of belonging among many foster youth in comparison with non-foster youth, and becoming pregnant to hold onto a partner. Foster youth might not obtain school-based sex education because many school districts do not teach it, because of the frequent changes in placement foster youth often experience, and because caregivers may withhold permission for their youth to participate. Although sex education workshops are offered through ILPs in many counties, not all youth participate in ILP, and of those participating in ILP, not all youth attend the sex education workshops that are offered. Youth who do get basic sex education may not be sufficiently cognitively engaged, motivated, or assertive to avoid unprotected sex. Youth expressed a strong desire for one-on-one support from a caring adult to help them think through sex-related issues and make wise choices, and they expressed disappointment in not having sufficient opportunity to discuss these issues with foster parents and CFS social workers and ILP caseworkers. When youth get pregnant, they do not always get counseling for pregnancy options. It appears that pregnant youth get prenatal care, although the responsibility for helping youth obtain this care is diffused across staff and caregiver roles. Staff do not consistently offer youth who become pregnant assistance in preventing subsequent pregnancy, nor do they discuss this issue with the pregnant youth's caregivers. CFS social workers and ILP caseworkers reported some discussion of prevention issues with youth, and tended to discuss these topics more frequently with female youth than with male youth.

#### **Theme 2: Barriers to addressing these needs and challenges.**

Several important barriers that stand in the way of addressing these needs and challenges were identified. These include unclear CFS and ILP policies about appropriate roles and potential liability, inadequate communication between CFS social workers and ILP caseworkers and foster parents and other caregivers, inadequate training of CFS social workers and ILP caseworkers, and a diversity of religious and moral beliefs and values among staff, foster parents, and group home caregivers.

#### **Theme 3: Suggestions from the participants regarding these needs, challenges, and barriers.**

Staff and youth made many suggestions for addressing these needs, challenges, and barriers. Several suggestions stood out across counties and roles, such as providing regular sex education

workshops open to all foster youth, having sex education start prior to the age of ILP eligibility and including peer-to-peer components, using graphic and community-prevalence information on STDs and especially HIV, training on condom use, and providing youth the opportunity to discuss sex education issues one-on-one with trusted adults in an atmosphere of safety and respect. Foster youth said they want more opportunity to discuss these issues with foster parents as well as with CFS social workers and ILP caseworkers. Foster parents, CFS social workers, and ILP caseworkers agreed that they need more training in adolescent sexual and reproductive health issues. It was also suggested that gender issues need to be better addressed, particularly a perception by males that protection is a female responsibility. Female youth expressed a need for a more customized approach to helping them protect themselves from pregnancy and STDs, one that takes into account their personal needs and preferences. Staff and youth recommended more information for lesbian, gay, and transgendered youth. Staff and youth also suggested that to be more accessible, information and resources for youth should be offered together, including increased access to condoms. Finally, staff said that pregnant youth should receive additional services for pregnancy counseling and the prevention of subsequent pregnancy.

## Recommendations

All youth should have one or more trusted adults with whom to discuss sexual and other issues they face as they deal with life's increasingly complex challenges. There is a compelling need to help connect transitioning foster youth to caring, committed adults who can serve in this role both before and after a youth has left care. In the long term, sex education and reproductive health services should be interwoven with other child welfare improvement efforts to holistically address issues such as absence of trusted adults, low expectations, and the need to belong, all of which can contribute to risky sexual behaviors and pregnancy. With this overview in mind, nine policy recommendations are presented and discussed below. These recommendations are derived directly from our findings in this study, and reinforced by the prior research we reviewed together with the review comments we received from a wide variety of CC25 and other experts and stakeholders.

**Recommendation 1: Counties should develop and implement specific policies, plans, and procedures to help prevent pregnancy and STDs and promote sexual health among foster youth. These should include specification of appropriate roles for all adults who care for youth, including CFS social workers and ILP caseworkers, public health nurses, foster parents, and other caregivers.**

Many staff and as well as foster parents are uncertain of their appropriate role in providing sex education, guidance, and resources to youth. In addition, many social workers and caseworkers are unclear about what can be discussed with youth without incurring potential liability or other legal issues. In addition to CFS social workers and ILP caseworkers, administrators who we interviewed also consistently expressed their beliefs that formal policies to clarify these issues are needed.

Foster parents share responsibility for the sexual and reproductive health of their youth as part of their broad parenting responsibilities. Nevertheless, youth placement changes, together with the restrictive religious and moral views of some foster parents and group home caregivers, make it imperative that not only foster parents, but also CFS social workers and ILP caseworkers be given explicit permission as well as clear expectations to discuss sex education and reproductive health issues with their youth. Similarly, some CFS and ILP staff also have moral or religious views that could restrict the range of options provided for foster youth to protect themselves from pregnancy and STDs. This reinforces the importance of having a clear policy that underscores the shared

responsibilities of all CFS and ILP staff, foster parents, and other caregivers in providing age-appropriate, medically accurate, and comprehensive information, guidance, and resources to all foster youth

**Recommendation 2: Foster youth should have regular access to ILP and non-ILP workshops on comprehensive sex education, including but not limited to methods of contraception and HIV and other STD prevention, personal goal setting, positive relationships, and information on what raising a child entails.**

Many ILPs currently offer sex education workshops a few times a year as part of their rotation of topics throughout the year. ILP sex education workshops should be offered more frequently, however, and they should discuss a range of options for contraception, as well as training on condom use. But not all youth participate in ILP. To augment the reach, extent and frequency of workshops offered through ILP, other community programs that present sex education workshops should be sought and utilized. Special efforts should be made to engage young men in sex education workshops and to emphasize male's equal responsibility for prevention. Sex education should be designed within a human development approach, with the goal of assisting youth transition into physically, mentally, and sexually healthy adults.

Workshops should provide foster youth with information to give them a full understanding of the consequences of having a child or acquiring an STD. To help youth to fully engage in the workshops and to integrate the information into their own lives, it can be effective to provide some of the information through peers. For example, workshops could involve presentations by foster youth who are parenting, to share their experiences, including the physical, emotional, and financial implications of having a child. To help youth personally take in the need for STD prevention, workshops could also include presentations from young adults with HIV, as well as provide graphics and statistics about STD and HIV prevalence in their own communities.

**Recommendation 3: Foster youth in their early teens should have access to sex education prior to becoming age-eligible for ILP.**

Not all foster youth receive sex education in public school—because it might not be offered at the school they are attending, because of placement changes, or because foster parents or other caregivers might not be willing to give permission for participation. Although sex education is offered in many ILPs, youth are generally not eligible for ILP services until they are in their mid-teens, after many have already become sexually active.

To help prevent early pregnancy, STDs, and sexual exploitation, it is important that CFS social workers and foster parents identify youth in their early teens who are not receiving sex education through their schools and link or provide them with community and other resources (including on-line resources) for age-appropriate,<sup>4</sup> medically accurate, and comprehensive sex education—before they become sexually active.

**Recommendation 4: Training should be provided on various aspects of adolescent sexuality and reproductive health for all CFS staff, including supervisory staff as well as social workers, and for ILP caseworkers and foster parents.**

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<sup>4</sup> Complete guidelines for age and developmentally appropriate sex education from kindergarten through 12th grade have been developed by the National Guidelines Task Force (2004).

This training should include the importance of sexual and reproductive health, confidentiality policies, methods of engaging youth in discussions, and the unique issues of males, females, and gay, lesbian, and transgendered youth. Social workers and caseworkers should also receive training on how to enhance their comfort levels with discussing sexual-related topics with youth and foster parents on these issues. Finally, training should include the identification of good-quality resource tool kits, web sites, handout materials, and information on local resources.

CFS social workers, ILP caseworkers, and foster parents all believed that they can benefit from training in these areas. Staff and foster parents believed that they need to know more about how today's youth think about issues related to sexuality, current methods of contraception and protection, and resources available in the community. Youth should have a role in providing this training. In addition, staff and foster parents wanted training on how to better engage youth in discussions on sex and protection, particularly with males. Finally, staff believed that they need additional training on how to engage foster parents in discussions on how to work with youth on these topics. Although social workers and caseworkers are often highly pressed for time, these staff were enthusiastic in recommending additional training for themselves around these issues.

**Recommendation 5: Staff and foster parents should routinely initiate discussions with youth around the issues related to sexuality, including self-image, relationships, goal setting, planning and decision making, and protection from STDs, unwanted pregnancy, and exploitation.**

Many youth want to have regular discussions with trusted adults about topics such as romantic relationships, the appropriate role of sexuality, and how to protect themselves from STDs, pregnancy, and exploitation. Because relationships with staff and with foster parents can be disrupted by change, these discussions should be initiated both by CFS social workers and ILP caseworkers and by foster parents. Regular discussion of these topics can help youth incorporate the knowledge they have, correct misunderstandings, normalize the discussion of sex and protection, and learn about community resources. By doing so, youth may be assisted in making good decisions, in overcoming denial, and in obtaining and using protection when they are sexually active.

These conversations should occur with males as well as females, tailored by gender, to emphasize the responsibilities of both males and females for contraception and STD prevention. To implement this suggestion, former foster youth could help staff develop a short set of standard questions for CFS social workers and others to use in initiating discussions with youth.

**Recommendation 6: Policies should be developed to ensure that a full range of services are provided to pregnant youth, including counseling on pregnancy options, assistance in preventing subsequent pregnancies, and linkages to providers of prenatal care.**

In the three counties studied, it was not clear from the data whether youth who get pregnant have access to counseling on pregnancy options. Hesitancy about the topic of abortion was expressed across two counties. Foster youth should have the same access to pregnancy counseling and abortion services as do youth who are not in foster care.

In addition, in the three counties studied, there were no formal policies or plans in place for providing pregnant and parenting foster youth with information and services to help prevent subsequent pregnancy. When youth become pregnant, staff and foster parent attention turns to providing prenatal care, and when the baby is born, to caring for the new baby. Adults may believe that by becoming pregnant, a young woman may have "learned her lesson" and will take the

necessary steps to avoid subsequent pregnancies after the baby is born. This is often not the case, however. Very soon after the baby is born, youth need help in obtaining appropriate contraception.

Adults from a variety of roles should each take steps to ensure that no pregnant youth “falls through the cracks,” with everyone assuming that someone else is taking responsibility for ensuring this.

**Recommendation 7: Information and resources should be presented together on-site, including condoms.**

Some youth reported feeling intimidated or embarrassed asking for information and contraceptives through a clinic and would prefer that ILPs provide both information and resources on-site. Condoms distribution on-site was also strongly recommended by youth. Requiring youth to request condoms kept in a locked cabinet—as opposed to having condoms offered, accessible privately, or otherwise readily available—was viewed as highly discouraging of condom use.

**Recommendation 8: Recruitment processes for caretakers in foster homes as well as group homes need to clearly state that foster youth must be allowed to attend school-based, ILP-based, and other community programs providing sex education.**

Some former foster youth, including those who had been placed in foster homes as well as in faith-based group homes, reported that while in care, they had not been permitted to participate in school-based sex education or ILP sex education workshops. While acknowledging that caretakers are likely to espouse their religious and moral views to the youth they care for, policies need to be developed to ensure that foster youth in placements operated by organizations and/or caretakers with deeply held religious views against comprehensive sex education have access to the same age-appropriate, medically accurate, and comprehensive sex education and reproductive health services as do other foster youth.

**Recommendation 9: Section 16521.5 of the California Welfare and Institutions Code should be fully funded and implemented. As a first step, a formal analysis of its current implementation should be conducted.**

In 1996, Assembly Bill 1127 added Section 16521.5 to the Welfare and Institutions Code. This section states that a foster care provider—or when the provider objects, the county case manager—is to ensure that adolescents in long-term foster care receive age-appropriate pregnancy prevention information. In addition, it states that a foster care provider—or when the provider objects, the county case manager—is responsible for ensuring that foster youth receive referrals to health services when they reach the age of 18 or are emancipated, whichever occurs first. Both provisions end with the caveat that they apply only to the extent that state and county resources are provided. Unfortunately, funding has not yet been allocated by the state legislature to implement these provisions.

Section 16521.5 also states that the State Department of Social Services, in consultation with the State Department of Health Services, is to convene a working group, to include specific representatives, for the purpose of developing a specified prevention plan. The plan was to include a) definitions of the roles of foster care and group home providers as well as the assigned case management workers in pregnancy prevention, b) a plan for involving foster youth peers, c) identification of appropriate materials to educate foster youth, foster care and group home providers, and county case management in adolescent pregnancy prevention, and d) materials and

methods for training the providers listed above. Section 16521.5 further states that the State Department of Social Services is to adopt regulations to implement the provisions listed therein.

In response to Section 16521.5, a working group was convened approximately 10 years ago and a sex education and pregnancy prevention curriculum was developed. It appears that *Power Through Choices*<sup>5</sup> is this curriculum. It further appears, however, that this curriculum has not been widely disseminated or implemented because funding was not provided for this. The materials that resulted from the working group should be assessed for their potential to serve as a starting point for updated, revised, and expanded curriculum that could be provided to each county's Department of Children and Family Services.

Section 16521.5 ends with the statement that the State Department of Social Services is to adopt regulations to implement this section, however no state funding was allocated for this effort, and to date these regulations have not been implemented. The development of regulations and funding resources that would allow for statewide implementation of Section 16521.5, in its entirety, would be a significant incentive to counties in developing and promulgating specific policies, plans, and procedures to help prevent pregnancy and STDs and promote sexual health among foster youth.

### **Conclusion**

The current CC25 Initiative assists youth transitioning from foster care by providing pro-social activities to encourage resilience and school retention, by teaching important life skills, by encouraging youth to set long-term goals, and most important, by identifying, developing, and maintaining committed relationships with significant, caring adults. Nevertheless, given the high rates of pregnancy and STDs among youth in foster care and the reported gaps in sex education and reproductive health services in the foster care system, more attention needs to be placed on addressing sexual and reproductive health needs of foster and transitioning youth.

Addressing these needs will require substantial long-term efforts, and counties cannot be expected to meet this obligation alone. Together with further developing their own resources and expertise in these areas, counties are encouraged to form strategic partnerships with other public and private agencies and with outside experts who are active in this field. These coordinated commitments and strategic partnerships will help ensure that sex education and reproductive health services play a larger role in a comprehensive, integrated continuum of services offered to foster youth to support a successful transition into adulthood.

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<sup>5</sup> We reviewed *Power Through Choices*, along with other curricula that have been cited in the literature as appropriate for foster youth, and the review is provided in Appendix A.

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## APPENDIX A: SEX EDUCATION CURRICULA FOR FOSTER YOUTH

The final component of this study was to identify and review available sex education curricula that were developed for or are commonly used with foster youth. We reviewed a variety of literature to identify these curricula. The identified curricula for which we were able to obtain manuals either in print or on the web are as follows:

- Power Through Choices
- Streetwise to Sex-wise
- Reducing the Risk
- Safer Choices

Each of these curricula is described below, together with information on how to order the manual. Key information about each curriculum's objectives, theoretical background, and strategies and materials is summarized. Finally, the use of these curricula by the three studied counties is reviewed.

### **Power Through Choices: Sexuality Education for Youth in Foster or Group Care (Becker, Barth, Cagampang, & White, 2001)**

Power Through Choices is a 10-session program for youth aged 14-18 years in foster care, including group homes, foster homes, kinship foster care, and residential care. The curriculum was developed by the Family Welfare Research Group at the School of Social Welfare at the University of California, Berkeley to help youth in foster care prevent pregnancy, HIV, and other STDs. Each session is designed to last 90 minutes. It is recommended that the curriculum be implemented within a period of one month or less.

The curriculum's objectives are to enable youth to (a) recognize and make choices related to sexual behavior, (b) build contraceptive knowledge and skills, (c) develop and practice effective communication skills, and (d) learn and practice locating and using local resources. The instructional approaches are based on research in behavior change and sex education.

Self-empowerment and the impact of choices on an individual's future are two major themes in the curriculum, and both are reinforced through interactive, practical, and skill-building activities in each of the 10 lessons. The curriculum focuses on recognizing and making choices related to sexual behavior, finding and using local resources, and developing effective communication skills. It emphasizes the importance of building skills related to effective contraceptive use and risk reduction techniques. The curriculum also discusses child sexual abuse, and sexuality and identity.

The curriculum is informed by the health belief model, self-regulation theory, theory of reasoned action and social cognitive learning theory. The health belief model states that readiness for action stems from an individual's perception of the threat of an undesired outcome and the likelihood of being able to reduce the threat through personal action, which is reflected in the curriculum's skill-building approach and youth self-empowerment. The self-regulation theory says that individuals attempt to bring their current states closer to their goal states, which is reflected in the curriculum by a focus on setting short- and long-term goals and the importance of planning ahead for safer sex. The theory of reasoned action states that behavioral intention is a strong predictor of behavior, which is reflected in the curriculum in an emphasis on making choices and the impact of choices on an individual's future. Finally, social cognitive learning theory states that actions are often

learned by watching others performs the actions and then practicing the actions oneself, which is reflected in the curriculum in the multiple opportunities for observation and practice through role play.

Power Through Choices can be purchased through the National Resource Center for Youth Services' Web site: <http://www.nrcys.ou.edu/catalog/product.php?productid=116&cat=17&page=1>.

### **Streetwise to Sex-Wise: Sexuality Education for High-Risk Youth (Brown & Taverner, 2001)**

Streetwise to Sex-Wise is a sexuality education manual for high-risk youth developed by the Center for Family Life Education at the Planned Parenthood of Greater Northern New Jersey. It is not intended to be an in-depth sexuality education curriculum, but rather a supplement that focuses on areas of particular concern to high-risk youth. The manual includes a background section containing a definition of *high-risk youth* and information on teaching sexuality education to this population.

The manual is divided into two series of lessons, one targeted at pre-teens and young teens, ages 9-13, and a second targeted at older teens, ages 14-19. The series for pre-teens and young teens has 11 lessons, whereas the series for older teens has 14 lessons. The lessons are designed to last 1.5 hours. Although each lesson builds on the previous lesson, each can stand on its own. Each lesson includes objectives, a rationale for the lesson, the materials needed to carry out the lesson, and the procedure for carrying out the lesson. The manual also includes a knowledge and attitude questionnaire for optional pre- and post-testing.

The lessons in the series for pre-teens and young teens discuss managing strong feelings and solving problems, male and female reproductive and sexual anatomy, puberty changes, sexual decision-making, birth control and communication skills, HIV and AIDS, safer sex and condoms, child sexual abuse, homosexuality, and dating skills. The lessons in the series for older adolescents discuss all of these issues (with the exception of puberty changes), and additionally includes pregnancy and birth control, date rape and assertiveness skills, relationships, finding accurate sexuality information on the Internet, and accessing sexual health services. The manual also discusses sexual health issues for four groups of high-risk youth population: (a) lesbian, gay, bisexual, and transgendered youth; (b) adolescent victims or survivors of child sexual abuse; (c) sexually abusive youth; and (d) pregnant adolescents and adolescent parents.

The manual states that lessons and activities that focus on skill-building, attitudes, and values should take priority over the teaching of factual information, as those lessons and activities are more likely to positively affect an adolescent's behavior than is an activity about the side effects of the pill. The lessons use many hands-on visual materials, which the manual states are more appropriate for high-risk learners.

This manual was reviewed in November 2003 by Minnesota Sexuality Education Resource Review Panel, the review panel required for funding by the Centers for Disease Control and Prevention. The panel found the manual to be clear, focused, and filled with high quality, accurate information. They highly rated the manual's clear messages regarding abstinence and the need for protection if sexually active, as well as the way it addresses communication skills and social pressures that influence sexual behavior. The only areas for which the panel indicated that the manual needed improvement were the quality of the graphic and visual presentation, and that the manual would be more user friendly if it had more easily reproducible materials, larger font, and better illustrations.

Streetwise to Sex-Wise can be purchased through Planned Parenthood of Greater Northern New Jersey's Web site: <http://www.ppgnnj.org/edu/index.php?sub=booksdetails&topic=streetwise>.

**Reducing the Risk: Building Skills to Prevent Pregnancy, HIV and STD (ETR Associates, n.d.a)**

Reducing the Risk was designed for high school students and includes 16 lessons that emphasize refusal statements, delay statements and alternative actions students can use to abstain or protect themselves. Each lesson is designed to last 45 minutes, but can be expanded to fill 90 minutes by increasing practice and discussion time.

The objectives of the curriculum are as follows: (a) students are able to evaluate the risks and consequences of becoming an adolescent parent or becoming infected with HIV or another STD; (b) students are able to recognize that abstaining from sexual activity or using contraception are the only ways to avoid pregnancy, HIV infection, and other STD; (c) students are able to conclude that factual information about conception and protection is essential for avoiding teenage pregnancy, HIV infection, and other STD; (d) students are able to demonstrate effective communication skills for remaining abstinent and for avoiding unprotected sexual intercourse.

The lessons discuss abstinence, sex, and protection with an emphasis on not having sex as well as on pregnancy prevention and HIV and other STD prevention; refusal skills; avoiding high-risk situation; getting and using protection; knowing and talking about protection; as well as integrating the skills learned through the lessons.

The curriculum is informed by three health behavior theories including social learning theory, social influence theory, and cognitive-behavioral theory. These three theories postulate that to reduce risk-taking behavior, people need to learn and personalize relevant information, recognize social pressures and anticipate risky situations, establish norms for positive behaviors, and learn and practice skills to act on the information and cope with social pressures.

Reducing the Risk can be purchased through ETR Associates' Web site: <http://pub.etr.org/ProductDetails.aspx?prodid=359>.

**Safer Choices (ETR Associates, n.d.b)**

Safer Choices is a two-year, school-based, multi-component HIV, other STD, and pregnancy prevention program for high school students. The curriculum is one of five components, and is taught in 20 lessons over 2 consecutive years; 10 lessons during the first year (level one) and 10 during the second year (level two). The lessons are designed to last 45 minutes, but can be extended by providing additional time for skill practice and discussion. Level two lessons reinforce and build upon level one lessons. Safer Choices assumes that students already have basic instruction on reproductive anatomy and physiology and puberty. The 10 lessons at each level were designed sequentially and are recommended to be delivered in the order presented.

The objectives of the curriculum are as follows: (a) students increase their knowledge about HIV and other STDs; (b) students have more positive attitudes about choosing not to have sex or using condoms if having sex; (c) students have greater confidence in their ability to refuse sexual intercourse or unprotected intercourse, use a condom, and communicate about safer sexual practices; (d) students perceive fewer barriers to condom use; (e) students have more accurate perceptions of their risk for HIV and other STDs; (f) students communicate more with their parents

regarding sexual issues; (g) students are able to use refusal and negotiation skills in sexual situations; and (h) students have reduced sexual risk behaviors, by choosing not to have sexual intercourse or by increasing condom use and use of other methods of protection if having sex.

The lessons discuss not having sex, understanding STDs and HIV, the risk of unsafe choices, using protection, the risks of pregnancy, avoiding unsafe choices, sticking with your decision, using condoms consistently and correctly, the influence of media, and resources.

Safer Choices is informed by social cognitive theory, social influences theory, and models of school change. Social cognitive and social influences theories hypothesize that in order to reduce risk-taking behavior, people need to learn and personalize relevant information, recognize social pressures and anticipate risky situations, establish norms for positive behaviors, and learn and practice skills to act on the information and cope with social pressures.

Safer Choices can be purchased through ETR Associates' Web site: <http://pub.etr.org/ProductDetails.aspx?prodid=H556>

### **Additional Curricula**

We identified an additional curriculum, **Crossroads: Choices for the Future**, but were unable to obtain a copy. This curriculum was developed by the Office of Family Planning at the California Department of Public Health and was delivered by Planned Parenthood of Orange and San Bernardino Counties about 6 years ago to incarcerated, probationary, and foster care populations, with the aim of decreasing unintended pregnancies among these populations. This curriculum was adapted from Streetwise to Sex-Wise and Power Through Choices. We were unable to locate either a copy of the curriculum or any person at the California Department of Public Health or Planned Parenthood of Orange and San Bernardino Counties who knew of it.

Two other potential curricula were identified, but not reviewed as they appeared less relevant to foster youth or of limited scope. The first was **Making Healthy Choices** (<http://www.lifespaneducation.com/educational.html>), which was developed for high-risk and incarcerated youth aged 14–21 years. It is a comprehensive curriculum that contains 63 highly interactive lessons. The seven unit topics include life cycle, sexual health, gender, attraction, relationships, exploitation and violence, and families. We did not review this curriculum because of its focus on incarcerated youth whose circumstances and needs differ from those of foster youth

The second curriculum was **POWER Moves: A Situational Approach to HIV Prevention for High-Risk Youth** ([http://www.rmc.org/Training/power\\_moves.html](http://www.rmc.org/Training/power_moves.html)). This is an HIV-prevention curriculum developed for adolescents who do not participate in traditional secondary school settings but regularly attend organized treatment or alternative education environments. It consists of 12 lessons that are designed to decrease the percentage of youth currently engaging in high-risk sexual and drug behaviors. Students are asked to set their personal limits and are taught negotiation and communication skills to keep those limits in difficult situations. We did not review this curriculum as it covers only STD/HIV prevention, which makes it limited in scope as compared with the other curricula we reviewed.

### **Program Evaluation**

Our overview of curricula that are available for foster youth can serve as a starting point for programs seeking to provide or augment their sex education for foster youth. The four main curricula we identified (Power Through Choices, Streetwise to Sex-Wise, Reducing the Risk, and

Safer Choices) have all undergone some degree of evaluation in regard to curriculum effectiveness for the intended population – foster youth specifically for the first two curricula and high school students more generally for the latter two curricula. Programs considering the use of these curricula may want to review these evaluations. Until additional rigorous studies are conducted to evaluate the effectiveness of these curricula for foster and former foster youth, these four curricula, with their promising but limited effectiveness evidence, might represent the best available resources for providing or augmenting sex education for foster and former foster youth.

### **County Curricula Use**

In Fresno County, ILP workshops on sex education and reproductive health are conducted by a CBO using both *Reducing the Risk* and *Safer Choices*. Both curricula were designed for high school youth. To take into consideration the additional issues and risks often experienced by foster and former foster youth, the CBO that conducts the workshops modifies the way the lessons are delivered by including more dialog and activities. In San Francisco County, ILP workshops on sex education and reproductive health are also conducted by a CBO. The *Safer Choices* curriculum is used, with some adaptations to meet local needs. Although sex education is provided, no curricula are used in Orange County.

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